South Carolina Department of Disabilities and Special Needs

Authorization for EIBI PDD State Funded Program Services

TO BE INVOICED TO SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MAIL INVOICE AND SUPPORTING DOCUMENTATION TO SERVICE COORDINATOR

TO: _____

_____

RE: _____
Recipient's Name / **Date of Birth**

_____
Address

_____
Parent Name / **Phone Number**

Service Authorization Number_____

You are hereby authorized to provide the following service(s) to the recipient named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorizations to this provider for this service(s).

Early Intensive Behavioral Intervention Services:

Annual Assessment (H0031): _____
Plan Implementation (H0032): _____
EIBI Lead Therapy (G0177): _____ units/week
EIBI Line Therapy (H0046): _____ units/week
Start Date: _____

Service Coordinator/Early Interventionist: Name / Address / Phone Number / E-mail **(Please Print)**

_____

_____

_____

_____
Signature of person authorizing services **Date**